Challenging experience to effectively protect the vulnerable population in Lao PDR

Sekeun Daniel Yu[1]*, Bouaphat Phonvisay[2], Maytry Senchanthixay[2], Bounlam Souvannasab[1], Jean-Marc Thomé[1]

1. Swiss Red Cross, Lao PDR, 2. National Health Insurance Bureau, Lao PDR, * Contact: Sekeun Daniel Yu sekeunyu@gmail.com

Introduction

- The Lao PDR has seen a rapid and steady expansion of the two important social health protection schemes for the vulnerable segments of the population, namely, the Health Equity Fund scheme for the poor (HEF) and Free Maternal, Newborn and Child Health services policy (Free MNCH). Initially largely funded by donors, this funding is now gradually being replaced with government contribution.
- The two schemes have paved a way for progressing towards protecting the poor, pregnant women and children and achieving universal health coverage, but also revealed substantial challenges and barriers in moving this agenda forward.
- The Ministry of Health National Health Insurance Bureau's (MOH/NHIB) recently introduced universal health insurance scheme for the whole informal sector population without targeting (National Health Insurance; NHI) is now opening up new opportunities and challenges in continuing and expanding protection for the vulnerable population group.

Methods

- This is a descriptive policy review on social health protection for the vulnerable population group in Lao PDR. A brief background on the HEF and Free MNCH is presented followed by an analysis on current challenges in continuing and expanding social health protection for the vulnerable segments of the population.

Financial health protection for the vulnerable population in Lao PDR

- The HEF and Free MNCH program aim at removing user fees and promoting access to health services in public health facilities for the poor, pregnant women and children.
- The Lao PDR officially introduced user fees in public health care facilities in 1995 with limited exemption of out-of-pocket payment for the poor, disadvantaged and vulnerable people.
- The HEF was introduced by an International Non-government Organization in 2004 followed by a major expansion in 2009 and 2011 with an arrival of more substantial funding support from donors. The Free MNCH was introduced in 2012 with funding support from donors targeting all pregnant women and children.
- The HEF and Free MNCH's bottom-up approach starting with the poor, pregnant women and children has undeniably provided a strong foothold in progressing towards achieving universal health coverage (UHC) and justification in expanding the financial health protection coverage to the remaining informal sector population.

Figure 1 (outpatient)

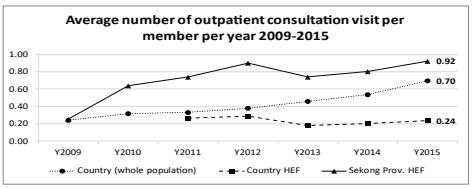


Figure 2 (inpatient)

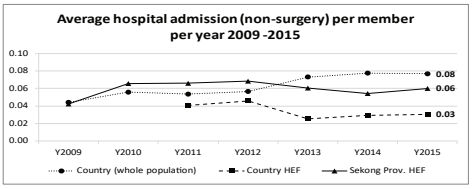
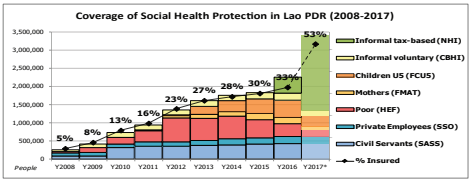


Figure 3 (social health protection coverage)



Challenges

Effectiveness and efficiency

- The official government list of poor households used by the HEF in most areas seems to underestimate considerable number of the poor with large exclusion errors. The official number of poor targeted using the list accounts for around 6% of the total population only, while the last national official economic and consumption survey show over 20% of the population is under poverty line.
- The HEF has still been unable to guarantee equal access to health care and deliver the same benefit package to the poor across the country. Figure 1 and 2 compares yearly utilization rate of outpatient and inpatient services by HEF members (at country level and for the best performing province) versus utilization by the whole population. The graphs clearly show relatively low yearly outpatient and inpatient utilization rate of HEF member at country level and suggest many poor are still experiencing considerable barriers in accessing health care. Meanwhile, higher utilization and demand by HEF member is experienced once health care is widely and continuously made freely available to them, as shown for this best performing province.
- Amounts reimbursed to providers by the HEF and Free MNCH program haven often been lower than what the health facility would have received by charging user fees. This often inevitably led to implicit rationing at facility level. The schemes' role as a demand-side financing mechanism has yet been limited in encouraging health facilities and staffs to provide a decent quality of care.
- Initially largely relying on external sources has led to high fragmentation of the HEF have been a major bottleneck for scale-up and integration.
- Inadequate and limited social functions has been played by the HEF and Free MNCH (promotion, information dissemination, orientation and welcoming services, providing food and transport allowances, feedback mechanism, problem solving, arranging referrals logistics). The two schemes have been in most districts mostly a subsidy fund closer to a supply side program rather than a demand side scheme to really remove barriers in access to health services for its members, and this has been particularly unfavorable for the vulnerable population.

Coverage and equity

- The new NHI's low co-payment strategy without targeting should allow more than 14% of the poor who were previously excluded from the coverage due to targeting errors to access health services at very low cost, if correctly implemented. The low co-payment is also expected to allow near poor group to have better access to health care (Figure 3).
- The NHI without targeting has potential implications on equity. It takes away the entitlement to receive free care, non-medical benefits from the poor as well as looses a track of the poor. Any payment charged on top of co-payment would have detrimental effects on the poor, worsen health inequity, and critically undermine the system.

Sustainability

- Funding for financial health protection of the vulnerable population group which has been largely funded by donors is now gradually being replaced with government contribution. Unfortunately, visibility and predictability of government funding for the vulnerable population group remains erratic. Poor budgeting, non-periodic release of funds and constant delay in reimbursement to health facilities also significantly increase risk of system failure especially when a large proportion of revenues are expected to be subsidized by the government.

Discussion and way forward

- The NHI must make the best out of a demand-side financing mechanism by significantly strengthening its strategic purchasing role. In particular, the social functions on top of the purely subsidy function is required if to ensure these subsidies are really pro-poor and effective in removing access barriers. Questions still remain on how to deliver these social functions needed in a non-earmarked government-led system, whether to keep it under the public system or externalize these tasks to outside organizations with specific social mandates.
- Other strategic purchasing strategies including clear purchaser provider split, equity-based monitoring, correct provider payment mechanism, and right incentives for members to compensate opportunity costs and create demand should be improved as these do make a difference and can yield better results in protecting the vulnerable population.
- For specific vulnerable population groups which include disabled people, non-registered poor, immigrants, people living with specific health and social poor conditions, mental disorders and others who have been traditionally neglected by the system, it may be better to continue specific programs with separate management and earmarked funding to allow for better monitoring and real support vulnerable population group. The cost of these would then be progressively included in the benefit package of the official health protection system in the future.